Application Form

Blue Option℠

Complete and sign the application.

BlueChoice® HealthPlan South Carolina

AX-425
P.O. Box 6170, Columbia, SC 29260-6170

Blue Option benefits are provided in network only. No benefits are provided for services received out of network unless the service is due to an emergency medical condition and the services are provided in an urgent care center or hospital emergency room.

SECTION A — APPLICANT INFORMATION

☐ Male ☐ Female Social Security Number: ☐☐☐-☐☐-☐☐☐☐ Date of Birth: ____ /____ /____

Last Name: _____ First Name: _____ M.I.: _____

Telephone Numbers: Home: (____)_____ Cell: (____)_____ Work: (____)_____

Street Address: _____ City: _____

County: _____ State: _____ ZIP Code: _____ Email Address: _____

Billing Address for Premium Notices (complete only if different from above):

Street Address: _____

City: _____ State: _____ ZIP Code: _____

How would you like us to communicate with you? ☐ Email ☐ Postal Mail

If email, an email address is required: _____

Your coverage effective date will be automatically assigned. Coverage will always be effective on the first of the month, except for birth or adoption. Coverage cannot be issued until the first month's premium has been received.

Are you a United States citizen? ☐ Yes ☐ No

If no, please provide the following: Document Type: _____ ID Number: _____

Check which enrollment option applies:

☐ Open Enrollment ☐ Special Enrollment

If special enrollment, provide the qualifying event: _____ Date of Event: _____

SECTION B — FAMILY INFORMATION — If Optional Family Coverage Is Selected

Coverage is available for dependent children through age 25. List dependents to be insured.

	Last Name	First Name	M.I.	Social Security Number	Sex	Birthdate	Height	Weight
Spouse								
Dependent								
Dependent								
Dependent								
Dependent								
Dependent								

☐ Check here if others are to be insured. List all pertinent information on another sheet.

SECTION C — BILLING INFORMATION

Initial Bill Payment (one time only):

- ☐ Credit/Debit Card — Authorization form must be completed.
- ☐ Bank Draft — Authorization form must be completed.
- ☐ Check
- ☐ Paper Bill

Future Payments:

- ☐ Bank Draft — Authorization form must be completed.
- ☐ Paper Bill

SECTION D — OTHER INFORMATION

1. Do you have Medicare, Medicaid, Medicare Advantage or any other health insurance coverage? ☐ Yes ☐ No
   If you answered "Yes" to 1:
   A. Company Name: _____
   Policy Number: _____
   B. Will this policy replace that health insurance? ☐ Yes ☐ No
   C. Other Coverage Effective Date: _____ Other Coverage Termination Date: _____
2. In the last six months, have you or anyone to be insured, if age 21 or older, used tobacco four or more times a week? ☐ Yes ☐ No

SECTION E — BENEFIT INFORMATION

Plan Name	Coinsurance	Deductible Individual	Out-of-Pocket Maximum Individual	Deductible Family	Out-of-Pocket Maximum Family
☐ Blue Option Gold 1500	35%	$1,500	$5,000	$3,000	$10,000
☐ Blue Option Gold 3000 HD	0%	$3,000	$3,000	$6,000	$6,000
☐ Blue Option Silver 2250	50%	$2,250	$7,500	$4,500	$15,000
☐ Blue Option Silver 3200	50%	$3,200	$7,900	$6,400	$15,800
☐ Blue Option Silver 4500	50%	$4,500	$8,900	$9,000	$17,800
☐ Blue Option Silver 4900 HD	0%	$4,900	$4,900	$9,800	$9,800
☐ Blue Option Silver 5550	35%	$5,550	$7,400	$11,100	$14,800
☐ Blue Option Silver 6250	25%	$6,250	$8,000	$12,500	$16,000
☐ Blue Option Silver 7350	50%	$7,350	$8,500	$14,700	$17,000
☐ Blue Option Silver 8200	0%	$8,200	$8,200	$16,400	$16,400
☐ Blue Option Bronze 6500	30%	$6,500	$8,700	$13,000	$17,400
☐ Blue Option Bronze 7000 HD	0%	$7,000	$7,000	$14,000	$14,000
☐ Blue Option Bronze 8000	50%	$8,000	$8,900	$16,000	$17,800
☐ Blue Option Catastrophic	0%	$9,100	$9,100	$18,200	$18,200

The Catastrophic plan is only available for people under age 30 or people who have a certification in effect that they are exempt from the requirement under section 5000A of the Internal Revenue Code of 1986 regarding individuals without affordable coverage or with hardships.

If you are working with an agent to purchase this policy, the agent's commission is $23 for a single policy and $51 for a family policy to be paid monthly, including upon renewal. Additional compensation may be provided for meeting new sales and renewal quotas. This commission does not add to your monthly premium.

SECTION F — AUTHORIZATION AND AGREEMENTS — READ CAREFULLY BEFORE SIGNING

The undersigned authorize(s) release to BlueChoice HealthPlan of South Carolina (BlueChoice®) or its representatives of all past and future medical records and other information deemed necessary by BlueChoice to review, process or investigate claims. This authorization for release of my past, present and future information includes Medicare Part A and Part B claims.

It is fully understood and agreed that no insurance coverage shall be in force until BlueChoice receives the application and the first month's premium payment and assigns the date on which coverage shall become effective. If this policy is canceled due to nonpayment and I apply for new coverage at any time thereafter, I understand that BlueChoice and/or its affiliated companies will require the payment of all past-due premiums before new coverage will take effect.

The undersigned hereby expressly acknowledges understanding this policy constitutes a policy solely with BlueChoice, which is an independent corporation operating under a license from the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. The Association permits BlueChoice to use the Blue Cross and Blue Shield service marks in the state of South Carolina, and BlueChoice is not contracting as an agent of the Association. The undersigned further acknowledges and agrees to have not entered into this policy based on representations by any person other than BlueChoice. No person, entity or organization other than BlueChoice shall be held accountable or liable to the undersigned for any of BlueChoice's obligations created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of BlueChoice, other than those obligations created under other provisions of this agreement.

SECTION G — SIGNATURE(S)

I have read and I fully understand every part of this application for insurance.

X _____ _____

Applicant's Signature — Date Signed

X _____ _____

Spouse's Signature (only required if applying for coverage) — Date Signed

Check here if dependent over age 21. Signatures are required.

X _____ _____

Dependent's Signature — Date Signed

X _____ _____

Agent's Signature — Date Signed — Agent's Code

For Office Use Only

☐ Credit/Debit Card (initial payment only) ☐ Check No.: ☐ Bank Draft

Reference No.: _____

Processed by: _____ Employee ID No.: _____

BlueChoice has free language interpretation services available. We can also give you information in languages other than English or other alternate formats.
For additional applications or answers to any questions, please call toll free:

855-433-2132

AUTHORIZATION AGREEMENT FOR PREARRANGED PAYMENTS

☐ **Bank Draft**

Bank Name: _____ Bank Routing Number: _____

City: _____ State: _____ ZIP Code: _____

Account No.: _____ Name on Account: _____

☐ **Initial Payment Only** ☐ **Recurring Payments**

Company Name: BlueChoice HealthPlan of South Carolina

I authorize BlueChoice HealthPlan of South Carolina to initiate debit entries to my checking account below and the bank named to debit my account. The authority is to remain in force until the bank/company has received written notification from me of its termination in such time and such manner as to afford the bank a reasonable opportunity to act on it. A customer has the right to stop payment of a debit entry by notifying the bank prior to charging the account. If BlueChoice HealthPlan of South Carolina initiates an erroneous debit entry to a customer's account, the customer shall have the right to have the amount of the entry credited to his or her account by the bank if, within 15 calendar days following the date on which the bank sent to the customer a statement of account or written notice pertaining to the entry or 46 days after posting, whichever occurs first, the customer shall have sent to the bank a written notice identifying the entry, stating that the entry was in error and requesting the bank/company to credit the amount to his or her account.

Bank Account Holder's Signature: _____

Print Bank Account Holder's Name: _____

Date: _____

AUTHORIZATION AGREEMENT FOR PREARRANGED CREDIT/DEBIT CARD PAYMENTS (INITIAL PAYMENT ONLY)

☐ **Credit Card**

☐ Visa ☐ MasterCard ☐ Discover

My Account No.: _____ Name on Account: _____

☐ **Initial Payment Only** Expiration Date (mm/yy): _____

Company Name: BlueChoice HealthPlan of South Carolina

I authorize BlueChoice HealthPlan of South Carolina to initiate a charge entry to my credit card below and the company named to charge my account.

Applicant's Signature: _____

Print Account Holder's Name: _____

Date: _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I authorize any entity covered by the HIPAA Privacy Rule as a covered entity or business associate to disclose to BlueChoice or its authorized representative my protected health information, prescription information, care or treatment provided to me, including without limitation information relating to autoimmune deficiency syndrome (AIDS), human immunodeficiency virus (HIV), or the use of drugs or alcohol.

I understand this authorization is voluntary and that such information will only be used by BlueChoice for the purpose of determining whether I qualify to be enrolled in a disease management, case management or wellness program.

This authorization is valid for one year from the date signed below unless earlier revoked. I understand that I may revoke this authorization at any time by sending written notice of my revocation to BlueChoice. I understand that revocation of this authorization will not affect any action taken by BlueChoice before my written notice of revocation was received.

I am making this authorization voluntarily and have had full opportunity to read and consider the contents of this authorization. I understand that BlueChoice will not condition the approval of this application or my eligibility for benefits upon my signing this authorization. I further understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws. Disclosure of my protected health information pursuant to this authorization may result in remuneration to the entity releasing the data. I understand that I may receive a copy of this authorization upon my request.

This only applies to applicants 18 and older.

Applicant's Signature: _____ Date Signed: _____

Applicant's Signature: _____ Date Signed: _____

Applicant's Signature: _____ Date Signed: _____

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。(Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839. (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ą́ąh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíį́ bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)

Vann du adda ebbah es du am helfa bisht, ennichi questions hend veyyich *deah health plan*, hend diah's recht fa hilf un information greeya in eiyah aykni shprohch unni kosht. Fa shvetza mitt en interpreter, roof deah nummah oh 1-833-584-1829. (Pennsylvania Dutch)